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Please complete both sides of this form.

Walgreens
Healthcare Plus

REGISTRATION & PRESCRIPTION ORDER FORM

1 0 1 O P T M A O P T 0 0 1

Please **PRINT** clearly using **UPPERCASE** letters. Use black ink only. Enclose this form with your mail service prescription.

OPTIMA AND SENTARA HEALTH PLANS

INTERCOM:OPTMA UPI:OPT001

MEMBER ID NUMBER (COPY FROM ID CARD)

S H

FILL IN WITH MEMBER ID NUMBER

#1 MEMBER INFORMATION

Name (First, Last)

Date of Birth (MM/DD/YYYY) Male / Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ 32-Codeine ☐ 87-Sulfa ☐ Other (list):
☐ 70-Penicillin ☐ 93-Tetracycline

HEALTH CONDITIONS:
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

IMPORTANT

It is standard pharmacy practice to substitute generic equivalents for brand drugs whenever possible. You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute or you specify otherwise (see below).

By checking this box, I elect to receive brand drugs for all prescriptions in this order whenever possible. By making this choice, I understand that under my benefit plan, I ***will be*** responsible for a higher copayment plus the difference between the brand and generic price of each drug.

PAYMENT (required at time of order):

Rx Type	No.	Cost (ea.)	Subtotal
Brand		$	$
Generic		$	$
TOTAL AMOUNT ENCLOSED			$

Signature (for credit card):

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; **no cash, please**) CREDIT CARD EXPIRATION

Checks payable to: **Walgreens Healthcare Plus** 7357 Greenbriar Parkway, Orlando, FL 32819-8917

CUSTOMER SERVICE: 1-800-999-2655 (☎ for deaf:1-800-925-0178)

REFILLS BY PHONE: 1-800-749-0009 (en español: 1-800-758-0002)

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

Thank you for your order. Please allow two weeks for delivery from the date you mail your order.

F1419/05-01

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#2 Dependent Information

Name (First, Last)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ 32-Codeine ☐ 87-Sulfa ☐ Other (list):
☐ 70-Penicillin ☐ 93-Tetracycline

HEALTH CONDITIONS:
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

#3 Dependent Information

Name (First, Last)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ 32-Codeine ☐ 87-Sulfa ☐ Other (list):
☐ 70-Penicillin ☐ 93-Tetracycline

HEALTH CONDITIONS:
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

#4 Dependent Information

Name (First, Last)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ 32-Codeine ☐ 87-Sulfa ☐ Other (list):
☐ 70-Penicillin ☐ 93-Tetracycline

HEALTH CONDITIONS:
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

#5 Dependent Information

Name (First, Last)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ 32-Codeine ☐ 87-Sulfa ☐ Other (list):
☐ 70-Penicillin ☐ 93-Tetracycline

HEALTH CONDITIONS:
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

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